



Washington State Department of Social and Health Services  
Medical Assistance Administration  
Coordination of Benefits  
P.O. Box 45561  
Olympia, WA 98504-5561

Do you have Medicaid AND  
pay for private health insurance?

*If you do, we may be able to  
help you pay your premiums.*

Washington State  
Department of Social and Health Services

Discrimination is prohibited in all programs and activities.  
No one shall be excluded on the basis of race, color,  
national origin, sex, age, religion, creed or disability.



DSHS 22-537(X) (5/02)



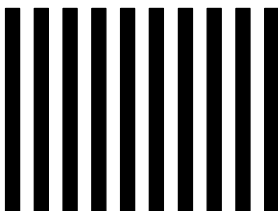
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WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES  
MEDICAL ASSISTANCE ADMINISTRATION  
COORDINATION OF BENEFITS  
PO BOX 45561  
OLYMPIA WA 98599-5561



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UNITED STATES



The Department of Social and Health Services (DSHS) offers a premium payment program for people who have Medicaid *and* private health insurance.

Often it saves money and works best for everyone if you keep your private health insurance and let us pay your premiums.

We pay your premiums and even pay for care that is covered by Medicaid but not covered by your private insurance. We encourage you to fill out and mail the application with this brochure. We'll let you know if this program will work for you.

How do you know if you have Medicaid?

Medicaid provides health care to low-income people of all ages. In Washington, people who have Medicaid are mailed a monthly green and white DSHS medical identification card. If you get this monthly medical ID card and you pay for private health insurance, we encourage you to apply to see if we can help you with premiums.

Does this program pay premiums for any kind of health insurance?

We pay premiums for many health insurance policies. There are some policies that we don't pay for – like insurance that supplements income or insurance that students get when they're in school.

Should you apply?


Yes! Once we get your application, we will let you know in about 45 days if this program works for you.

If you have questions, call toll free: 1-800-562-6136

Coordination of Benefits  
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Administration  
P.O. Box 45561  
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Detach, fold, and mail in the attached envelope.



Application for DSHS Premium Payment Program

1

Your name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone Number: \_\_\_\_\_

2

Do you have Medicaid *and* Medicare? Yes ☐ No ☐  
  
If yes, do you pay premiums for a Managed Medicare Policy? Yes ☐ No ☐

3

Private health insurance *Please fill out the all the information below or send us a copy of your insurance card.*  
  
Name of health insurance policy: \_\_\_\_\_  
Company Address: \_\_\_\_\_  
Telephone number: ( \_\_\_\_ ) \_\_\_\_\_  
Subscriber Identification Number (may be a group or medical record number): \_\_\_\_\_

4

Medicaid *Please fill out all of the information below or send us a copy of your latest green and white medical ID card.*

Name	Date of Birth	Social Security Number <i>(Optional)</i>	Are they covered by your private health insurance?	
1. _____	_____	_____-_____-_____	Yes <input type="radio"/>	No <input type="radio"/>
2. _____	_____	_____-_____-_____	Yes <input type="radio"/>	No <input type="radio"/>
3. _____	_____	_____-_____-_____	Yes <input type="radio"/>	No <input type="radio"/>
4. _____	_____	_____-_____-_____	Yes <input type="radio"/>	No <input type="radio"/>
5. _____	_____	_____-_____-_____	Yes <input type="radio"/>	No <input type="radio"/>

5

Premium  
How much is your premium? \$ \_\_\_\_\_  
Is this amount deducted from your paycheck weekly? Yes ☐ No ☐ every 2 weeks? Yes ☐ No ☐ monthly? Yes ☐ No ☐  
  
If yes, write in the name address, and telephone number of your employer or send us a copy of your pay stub showing the deduction.  
  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone number: ( \_\_\_\_ ) \_\_\_\_\_

6

By signing this application, you are giving your insurance company permission to release your insurance information to us.  
  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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DSHS 13-705 (5/02)